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RESEARCH

Symbolic fights of nurses in implementation of the program of family health

Lutas simbólicas das enfermeiras na implantação do programa saúde da família

Luchas simbólicas de las enfermeras en la implantación del programa de salud de la familia

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ABSTRACT

Objective: To describe the symbolic struggle of nurses in the implementation of the Family Health Program in Teresina and analyze the strategies undertaken to ensure their participation in the program. **Method**: historical-social study, we used the concepts of Pierre Bourdieu as a theoretical framework, oral and documentary primary sources. Oral sources were derived from interviews with 11 nurses and a member of the health management who experienced this process. After the completion of each interview were performed transcription and thorough reading of the same, in order to organize the document body to be worked. **Results**: As they were acting, the nurses began to fight for the overthrow of the ruling power, established strategies in the processes of selection and hiring, updated the professional habitus, reacted as the wage gap between doctors and nurses and claimed professional autonomy. **Conclusion:** Nurses gained ground through struggles undertaken and even often at a disadvantage in relation to the domination of the field, demonstrated strength and resilience. Descriptors**:** History of nursing, Nursing, Family health.

RESUMO

Objetivo: Descrever a luta simbólica das enfermeiras na implantação do Programa Saúde da Família em Teresina e analisar estratégias empreendidas para assegurar sua participação no Programa. **Método**: Estudo histórico-social utilizou-se conceitos de Pierre Bourdieu, como arcabouço teórico, fontes primárias orais e documentais. As fontes orais originaram-se das entrevistas com 11 enfermeiras e um membro da gestão de saúde que vivenciaram esse processo. Foram realizadas a transcrição e leitura minuciosa das mesmas, de forma a organizar o corpo documental a ser trabalhado. **Resultados**: À medida que atuavam, as enfermeiras passaram a lutar pela subversão do poder dominante, estabeleceram estratégias nos processos de seleção e contratação, atualizaram o habitus profissional, reagiram quanto às diferenças salariais entre médicos e enfermeiras e reivindicaram autonomia profissional. **Conclusão**: As enfermeiras conquistaram espaço por meio de lutas empreendidas e, mesmo muitas vezes em desvantagem em relação à dominação do campo, demonstraram força e superação. **Descritores:** História da enfermagem, Enfermagem, Saúde da família.

RESUMEN

Objetivo: Describir la lucha simbólica de las enfermeras en la implantación del Programa de Salud de la Familia en Teresina y analizar estrategias emprendidas para asegurar su participación en el programa. **Método**: Estudio histórico-social, se utilizó conceptos de Pierre Bourdieu como un marco teórico, fuentes primarias orales y documentales. Las fuentes orales se derivaron de las entrevistas con 11 enfermeras y un miembro de la administración de la salud que ha experimentado esto proceso. Fueron realizadas la transcripción y la lectura completa de las mismas, con el fin de organizar el cuerpo del documento que será trabajado. **Resultados**: A medida que actuaban, las enfermeras empezaron a luchar por la supervisión dominante, establecieron estrategias en los procesos de selección y contratación, actualizaron el habitus profesional, reaccionaron cuanto las diferencias salariales entre los médicos y enfermeras y reivindicaron la autonomía profesional. **Conclusión**: Las enfermeras conquistaron espacio a través de luchas llevadas emprendidas y, mismo muchas veces en una situación de desventaja en relación con el dominio del campo, demostraron fuerza y superación. **Descriptores**: Historia de la enfermería, Enfermería, Salud de la familia.

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INTRODUCTION

The object of this study are the symbolic struggles undertaken by nurses in the process of implementation of the Family Health Program (FHP) in Teresina. The starting point corresponds to the year 1996 and is linked to the beginning of the performance of the nurses in this specific field and ended in 2000, when they were enforced by the first tender for professionals working within the Program.

To understand the problem of this study is to consider that in the period 1996-2000, the model of health care in the country was undergoing changes resulting from the creation of the Unified Health System (SUS), such as the reorganization of primary care initiated with implementation of Community Agents Program (PACS) in 1991, and the Family Health program (FHP) in 1994.[1]

The CHAP was created as a state program, with the purpose of expanding the coverage of health actions in rural and urban fringe areas, to contribute to the reduction of maternal and infant mortality, focusing on the North and Northeast regions, with a focus on family unit programmatically health action.[2]

To make the desired changes occurred in the country's health system, was necessary to reframe the role of health professionals in primary care, given that the new health policy required a committed to achieving the principles of the SUS in professional practice daily, and this requirement was not referring only to new professional groups, such as community health workers, but particularly to traditional categories, such as nursing.[3]

In this context, the nurses started their operations in this space in a strategic position with respect to the redefinition of the health model in the country and became supervisors of the actions of community health workers in primary care, directly contributing to the establishment and implementation of the new policy . The performance of these professionals, the orientation of strategies and ways to prevent, care for, treat, and monitor individually and collectively health contributed to the changing epidemiological profile of the country's.[4]

From the success of the PACS FHP was established in 1994, aiming to break the passive behavior of the basic units, extending the actions of health in the community. Thereby, the FHP incorporates SUS principles of universal access, decentralization of management, completeness and fairness of the attention and participation of the community, with the potential for building a model of resolute and full health in cities small and medium sized.[5]

The discussions around the implementation of the PSF, in Teresina, started in 1996 with the creation of three pilot teams in rural areas of the city, as experience in this type of attention. The sites chosen were those where longer worked PACS, as they existed the community health workers and teams were complemented with other professionals. After one year of this experience, seventeen new teams were created, particularly in regions where there was no type of health care.

In this sense, the nurses were important characters in the changes in health care in the country, and this initial moment, both the PACS as the FHP, was marked by historical aspects, as they relate to social relations within that space, which can be perceived singular form in the trajectory of this professional category.

In Teresina the fights taken by the group of nurses in the FHP implementation process are relevant to help in understanding the socio-political forces and the field of health, which interfered with the construction of a structure of primary care. Therefore, the understanding of this process will help you to view the past and provide

a perspective of the future of these professional space in this specific field.

This way, the contribution of this study were already published on the subject is evidenced by the depth of the discussion on the problems that arose, and, somehow, still stands on the goals and symbolic limits for these professionals, in addition to treating a history of struggle and resistance of nurses, the Family Health program in Teresina, involving the symbolic effects of the hegemonic power, which is made explicit in the materialization of the social division of labor in the Family Health Program.

Regarding the problem described define the following objectives: Describe the symbolic struggle of nurses in the implementation of the Family Health Program in Teresina process and analyze the strategies undertaken to ensure their participation in the program.

METHODOLOGY

This study is of historical-social nature, in which the concepts of habitus, field, capital, power and symbolic violence of the French sociologist Pierre Bourdieu are used as part of the theoretical framework. The habitus as a generative grammar of practices as the objective structures of which is product[6], classifies and hierarchizes the individuals or groups in different social spaces, since the habitus not only internalizes the outside but also the inside outward. This notion allowed to explain the relationship of affinity between the strategies of nurses and the objective structures of the space occupied by them, in this study symbolized by the Family Health Program.

The field concept was conceived as a structured social space, a field of forces, where there are dominant and dominated, in constant interaction, struggle to preserve or transform this force field, producing actions.[7] This concept was useful to the analysis of data on the distributional aspect of the habitus of the nurses, which helped to mark the positions of the Family Health Program in Teresina.

In every field symbolic struggles occur for symbolic power, that is, the "power to be given by the utterance, to see and believe, of confirming or transforming the worldview, and thus the action on the world "[7].

In this perspective, the nurses come in a "game", seeking recognition in social space and for "this game to happen," disputes are waged within the search field in defining rules and maintaining a strategic position.

In this perspective, the nurses come in a "game", seeking recognition in social space and to "this game to happen,[7]" disputes are waged within the search field in defining rules and maintaining a strategic position. This is because individuals or groups are embedded in social structures in positions depend on their capital and develop strategies that depend, in large part, these positions within the limits of its provisions. And the more people occupy a favored place in the structure, but they tend to be retained, at the same time, the structure of a social trend, which are more or less appropriate to its position.

As regards the production of the data was performed in the months of January, February and March 2011, through oral and documentary primary sources. Oral sources were derived from interviews with the subjects constituted in eleven respondents, ten nurses who experienced and participated in the implementation of the FHP in Teresina and a representative of the Municipal Health Foundation composing the health management process at the time.

The search for subjects was initially through the Municipal Health Foundation of Teresina, who reported on the existence of a cooperative officials FHP during this period. Thus, we seek those

responsible for the extinct cooperative, which provided the identity of the first nurses and reported current contacts or workplaces. As inclusion criteria of respondents, use the following: having started work as nurse at the FHP Teresina in 1996 and 1997.

The interviews were conducted by two semi-structured with open questions roadmaps: a model was applied for nurses and one for the office of municipal management. After prior appointment by telephone interviews were conducted in the most appropriate location for the subject, which, in most cases, chose their own work environment, and were recorded in mp4 player, lasting approximately 1 hour and 30 minutes. Interviews ceased when was data saturation, when we identify repetition of the interviewees' statements.

After the completion of each interview was effected transcription and detailed reading in order to organize the document body to be worked. Thus, was performed the process of assessment and validation, in which the document was criticized in the search for historical evidence that supported the study through two types of criticism, the external, which assesses the nature of the document, and the inside, which seeks to apprehend meanings.[8]

After the identification and classification of sources, we must determine the quality and relevance of information, a process through which one evaluate and validate these data, determining the historical evidence on which the researcher will rely to interpret or verify their hypotheses.

Still used as primary sources of documentation from the Health Foundation and the Cooperative Health Professionals in the State of Piauí, who constituted in ordinance, resolution, projects, management reports and studies on the process of implementation of the FHP in Teresina that complemented the documentary corpus of research and contributed to the analysis of it in its entirety. Was used as a secondary source books, articles, Laws, Ordinances and Regulations of the Ministry of Health and other publications specific context of the era that produced the study in political, economic and social perspectives.

The criteria established by Resolution No. 196/96 of the National Board of Health were followed. The subjects were informed about the objectives of research and ethical issues related to research involving human subjects, including the possibility was emphasized, if they wished, desist from participation at any time, even after signing the Consent Form, which was read by the subjects and signed by them in two copies, one of which was delivered to the interviewer while the other stayed with the respondent. This study was approved by the Ethics Committee in Research of the Federal University of Piauí, on November 26, 2010, Opinion No. 0254.0.045.000-10.

RESULTS AND DISCUSSION

Nurses in the process of implementation of the Family Health Program

The accession of the city of Teresina in the Family Health Program was initiated with the adoption by the City Council of Health in May 1997, of the Project Implementation twenty Family Health Teams, which were specified in the municipal figures, the structure of health the prediction operational teamsthe form of selection and hiring of professionals and monthly remuneration. With the approval of this project, the foundation for primary care were established in Teresina.[9]

Regarding the composition of teams, the Ministry of Health recommended that were composed of a doctor, nurse, technician or nurse and community health workers.[9] In the local context the question was included in the municipal

deployment project the FHP, therefore, managers knew the framework structure than would be deployed.

The structure of the FHP in Teresina was composed by agents who participated in the design of this space, which in the municipality were the Municipal Health Foundation (FMS), subordinate to the Municipality of Teresina body, represented by the managers of the health system, usually doctors, whose functions were to structure the operation of the field, manage the resources, hire the professional teams and arrange the service according to the guidelines of the Ministry of Health, medical teams, who performed hegemonic position in the field to be holders of scientific, economic and symbolic capital in situation of health services; teams of nurses, who brought as capital accumulated experience in the field of PACS and affinity with the work in the community, the community health workers and nurse assistants, that existed in the district health and were availed to the Family Health program and service users.

The context in which occurred the spatial design of the agents involved in the FHP and the relationships between these groups, motivated by disputes within that space was crucial to the formation of its structure and the positions taken on by agents.

Therefore, from initial planning nurses were included as members of the proposed health care and certainly the experience acquired as a supervisor of community health workers in PACS contributed to accumulate capital in the area and had support with the Program.

> *When I graduated I went to work in a municipality to implement the PACS, so I had a vision of what was to work with primary care, health promotion (E1).*

With this prerogative, nurses have become promising agents of change in of the health care process model.

Accordingly, the recognition fundamental values, knowledge about the history of the field and possession of specific capital are necessary requirements for insertion of an agent in a particular field.

This is because the effects exerted by new experiences on the professional habitus of nurses depended on the practice compatibility relationship between new experiences and others that were already integrated into habitus.

From the formalization of the commitment of the municipality to implement teams, the next step was the recruitment of professionals for the selection process, comprising the steps of interview and resume analysis, which were performed by evaluators of the Federal University of Piauí, of the Municipal Council Health, Municipal Health Foundation and the State Department of Health.[9]

However, impasses occurred at the time of implementation of the FHP in Teresina related to the selection and hiring of members of the Family Health Teams as the witness reports.

> *At that time, we did a survey to see how the staff of the Family Health Teams were selected and contracted in Brazil and found that there were 28 different forms of contracting, sometimes with a contract without value, without contest, for political statement, of all ways. Why? Because most of the payment of these professionals was conducted by the Ministry of Health, only which it checked off the money to pay the salarybut it does not assumed responsibility for retirement, removal, vacation, the thirteenth salary. So difficult was this management work, when it transferred the responsibility of the federal government and the states to municipalities (RGM. 01).*

This process contributed to the municipalities adopt these practices for professional binding, as if acceptance of these professionals was conducted through public tender would create employment link with the municipality, which also assume the expenses in relation to the charges, but that expense was not provided in transfers of funds from the Federal Government for the Family Health program.

However, the Ministry of Health argued that conflicts with regard to the selection of professionals was due to a lack of understanding of the proposal, and directed to some forms of selection, such as resizing of existing human resources in the municipality and internal selection, and also suggested selection process that was carried out or just curriculum analysis and interview.[11]

In 1997 a selection process consisting of interviews and analysis of curriculum that was asked from the stage of distribution, as testimony was held:

> *In this period began the selection of nurses and doctors, we take our curricula, which were evaluated, some were called, not all, and went through an interview that included what we knew about the Health System (E 2).*

After the completion of the selective testing, municipal management was informed that the process performed had problems.

> *The test was not considered selective tendering because if I'm not mistaken lacked a written test, do not remember much, just know that later led to a lawsuit (RGM.1).*
> *To remedy the issue municipal management suggested that professionals would create a cooperative called Cooperative of Professional of the Family Health Program "example of what was happening in other states, especially in Pernambuco, we founded the cooperative and we worked as contractors and assumed the onus its own hiring. (E 3)*

As we reflect on this phenomenon, in which management suggests a type of contract for professionals, we rely on the concept of symbolic violence which is defined as a process whereby the dominant agents impose their worldview to the dominated the agents, and the complicity of these, since they recognize the need for this rule, putting themselves in a subordinate and passive role.[12]

From this perspective, when dealing with a segment of the state, one of its main powers is to produce and impose their ways of thinking about the world that we use, and the state itself. Therefore, the state successfully claims the monopoly of legitimate symbolic violence in a given territory and on the set of the corresponding population.[10]

At this juncture, the municipal management district represents the power of the state, which through administrative, financial and legislative interventions, legitimized by their symbolic capital, regulated the process of implementation of the FHP in the health field. Thus, by accepting the imposition, nurses reaffirm its position of dominance at that time, and, therefore, also accept the position assigned to them.

Nurses have assumed the administrative routine of the Cooperative and spent time in managerial activities in relation to the group of top-level professionals hired by the municipality to the Family Health Program.

> *We had to take the lead, going after accountant, lawyer, joint business, to organize the documentation (E 4).*
> We were going to any room of the Foundation or in the home of someone and did checks on these makeshift sites for each employee, who signed a payroll (E 10).

However, the struggles surrounding the hiring of nurses for the FHP was not completed by the creation of the Cooperative. Two years after its creation, there was a change in the type of contract these professionals became a commissioned positions. The council broke the covenant, with the justification that the type of contract for cooperative was not a legal way to bond with the institution, although they knew that from the first moment.

Although the FHP has been prepared by the Ministry of Health, the implementation of it was due to the proposed membership of the municipalities, and this process consisted of several steps, in which the council had to meet certain requirements, such as: establish the functioning of the Municipal Health Council and the existence of a Municipal Health Fund, secure infrastructure necessary for the operation of teams and to provide a support network for diagnosis and treatment of greater complexity.[13]

However, initially, the FHP did not find a favorable environment for strengthening your scenario because the formulation process was not fully completed and the necessary conditions for its sustainability were not sufficiently defined at the institutional level. There was, therefore, definitions on their financing and not as the human resources policy and addition to these restrictions, there was the very resistance to implementing a proposal that confronted the traditional forms of organization of health services.[11]

Thus, the contract of the nurses with the municipality through the Cooperative lasted from October 1997 to May 1999, when it undone and became a contractual form of commissioned positions within the organizational structure of the Municipal Health Foundation:

> *We had to stop Cooperative, city managers claimed that we could not continue because it is not a legitimate contract and other sites that worked well no longer work anymore (E 9).*

Given the fragility of these forms of contract with regard to labor laws, the reported situation also lasted for a little while, until clearly defined forms of funding from the formulation of the Basic Operational 01/1996, according to which every municipality spent receive a specific amount passed by the National Health Fund to fund primary care, what was then, in 1998, the FHP received a boost in its implementation[14].

> *In 2000 there was an competitive examination of tests and selection of titles for the FHP and all study nurses attended the event equally in relation to other candidates. "We were told they could no longer continue as a commissioned position, then there was the public tender, and it was suggested that all we did and few did not do (E 3).*

From then on, they began to work more safely in having job security, however, the years worked were not computed for the benefits from the time of service. In the present day still lingers a lawsuit on that aspect.

This panorama of uncertainties on the recruiting of Professional Teams reflected the difficulties faced by managers to break the model of previous attention, considering that the beginning of the change process would lead to the selection of professionals. Thus, the management sought subterfuge to delay this step, since the change in modality of care would transform the rules of the health field, and therefore threatened the position of the dominant.

Thus, even under the conditions mentioned, the nurses participated in the process and preferred to fight for a repositioning in the health field, because with the implementation of the FHP

they glimpsed jobs and new employment opportunities.

Nurses and symbolic fights in the context of health program family

After the obstacles in hiring the professional group held a "Introductory Training" offered by the Ministry of Health to ascertain the Program guidelines and their application in practice. With this procedure began the process of upgrading the professional habitus, to legitimize this space, because with the change in the form of assistance to the population, the professionals involved should acquire the provisions required by the healthcare field, so that they could develop them in practice.

> *Shortly after hiring, started the Introductory Training for all staff who were involved at the time of the program. The technicians of the Ministry of Health would like to be shown how the actions performed, explaining the guidelines, for us to initiate the work. (E 5)*

This training enabled professionals to analyze together with the community, the status of their coverage area, with regard to demographic, socioeconomic, environmental and health issues, identifying problems and existing potential and understand the indicators of the Information System Primary Care (SIAB) to establish mechanisms for monitoring and evaluation of the activities, which offered support to the decision making process of the Family Health Unit.[14]

Beyond this initial activity, the nurses also held other investments in continuing education in the area of primary care, which are described in the Management Report of the Health of Teresina in the year 1997, which are listed twenty-two professional development courses with the approach of FHP related topics, such as diarrhea, breastfeeding, women's health, immunization, among others.

> *"Right now we have made valuable courses for that reason I think it was a gain for the professional, we work with the political security" (E 7).*

These investments have provided an advantage in the relations of forces undertaken in the field of health in relation to other agents involved in this social space. That's because one of the factors that determine the most significant social differences in careers is the art of anticipating the trends that "lets hold up the good topics in good time.[12]

Following the events professionals began working after stocking in neighborhoods as geographical distribution by the Municipal Health Foundation From then be put into practice a model of primary care with the insertion of the teams in the area, at which time the population would meet the proposal of the Family Health program the representative of the municipal administration recalls the insecurity of all that time:

> *Given the doubts and worries and my professional, remember that I said "come in the area, feel and do." It was an experience that started from scratch and no had very clear what was to be done and how these new rules would be reflected in practice, oriented only to attend to all well and seek to understand the difficulties of each region (RGM 01).*

Anticipating such difficulties, the Municipal Health Foundation hired a Cuban advisory for the guidance of professionals, as in Cuba, the Family Health Program was established as a successful experiment in terms of the organization of care.

> *At that time the council invited a couple of Cubans, a doctor and a nurse, to pass on the idea of working in family health in Cuba and was very important, because they went with us to the*

> *community and showed as it did in their country (E6).*

The health care system in Cuba was considered avant-garde in Latin America, and had their bases in Primary Health Care, where the Family Health Program was implemented in 1984 and, later that same year, had a coverage of 50 % of population.[15]

As the FHP was consolidated in Teresina, the actions of the nurses was happening amidst the struggles undertaken by these professionals. For example their salaries unleashed struggles category, because conflicts that formed in that context were primarily related to the difference in amounts paid to professionals between regions and between members of higher level staff.

> *Our great struggle was the issue of salary, at the time said that the amount paid was the same offered in other states. We get a liquid far below of the doctor, it provoked us much, because no matter what we tried to say that we had a team work, always was left to the nurse the accumulation of functions (E1).*

The funding of the Family Health Program provided the same value for health team deployed to all regions of Brazil, however, the responsibility for defining the incentives paid to professional teams was left to the municipalities, there was no regulation on the amount of salary professionals. What existed was the guidance on the financial contribution of the municipal government, which should complement the cost of teams.[16]

The wage difference between doctors and nurses of FHP we recognize a form of symbolic violence against nurses who were not the hegemonic group and being stipulated a much higher salary quota for the medical professional can be understood as a symbolic strategy for naming this as the professional holder of symbolic capital and, therefore, the dominant players in the field. Still in this perspective, the symbolic power is an invisible power that diffuses into the social fabric, structuring behaviors and values, and it happens with the complicity of those who do not exercise[7].

Thus, the symbolic power exercised by the medical profession was acquired in the course of its history, imbued with relations of domination and strategies of accumulation of prestige, and was not recognized as arbitrary, which contributed to the continued hegemony of this group in the field of health.

It should be emphasized that the deployment of the teams occurred at the same time when the health service is structured and, in these conditions, the nurses began to demand better working conditions, including actively participating in decisions related to construction of health facilities.

> *I am gratified to have insisted for a health center for the region that I worked, it was a challenge for me, but gratifies me very much, I found a site, I made contact with the owner of the land, took the President the Superintendence of Urban Development in the region to talk to the owner of the land, intermediate negotiation and Municipal health Foundation bought the land and built the health center, which is now in place that idealized (E8).*

Through the testimony we realize that nurses articulate necessary steps for building the network in primary care and, thus, stood out compared to other professionals in structuring the FHP, to expand its operations and contribute to the strengthening of the proposal.

With this gesture, nurses articulated the necessary steps for building the primary care network, and collaborate for the organization, it stood out in the structuring FHP and won support in their requests along to managers, since, by these

professionals also would be defined as the support necessary for the operation of services. In this process, nurses accumulated specific capital, so that later can be translated into symbolic goods in the form of prestige and recognition.

Other aspects of the role of nurses in the FHP refers to direct contact with families when they realized that the work would be much more comprehensive and complex, because the unfavorable socioeconomic conditions of families, lack of infrastructure areas and the very culture of the population directly influenced the understanding and acceptance of the proposal.

> *We start to live with constant anxiety because suddenly faced with the social issue there in our eyes, were very poor families, the violence that we start watching closely, because all weekend was a death due to violence, drug issue, a reality that out of the Family Health program we do not seen, within the hospital we received the patient, but we have no idea how everything is happening (E4).*

The living conditions of the population caused at that time, an impact on nurses, awakening in them reflections on social issues that influenced this context and how the FHP proposed facing health problems directly in the community, nurses needed special dedication, completely different those required in their previous work experience[16].

> *Thus, at the time that anguished with the conditions encountered, they seem trying to change this reality. "When I encounter these situations and came home with ample food and the right to choose what to eat, so thought in those people who they had no food. It was a great social shock (E 4).*

This scenario initially sparked emotional exhaustion in professionals, who subsequently sought to adapt to the context, allying themselves to the community in order to satisfy their needs.

> *In my area there unfiltered water, so I had the idea to get a few filters with businessmen, and this idea worked, gave a filter for each family in my area. (E8).*

In this sense, the nurses were significant agents of change in the care model, capable of changing the profile of health facilities, through dynamic innovative work, committed to the project to strengthen the Family Health Program.

At the time when contributed to the structuring of the FHP, the nurses demonstrated their importance at that time, representing a symbolic gain for these professionals as the improvement of working conditions and assistance to the population would be linked to the projects developed by nurses for this purpose.

CONCLUSION

Symbolic struggles undertaken by nurses within the Family Health Program were key to its (re) taken of position in the healthcare field because if it started in the admission process, we identify the symbolic violence by the authorities to carry out a selective test without legal support, to guide for creating a cooperative and also when, after three years in the program underwent a new selection through tendering of tests and titles.

To make investments for positioning in the space the FHP, the nurses also undertook struggles on issues related to the salary difference between doctors and nurses, as well as the definition of roles within the team. On these issues, the symbolic capital of the endorsed medical professional to maintain their dominance in the health field.

In this sense, the incorporation of the new professional habitus, which happened through specific training nurses could act in the space the FHP and sought these opportunities as a means of capital accumulation, which became symbolic weapons during their operations in Family Health program. As components that also influenced the incorporation of habitus nurses, highlight previous experience of the class and the very identification of these professionals with the new policy.

The role of nurses in the FHP implementation process was characterized by the conquest of space by means of symbolic struggles undertaken by this group of professionals, it often disadvantaged by the effects of symbolic domination, however established strategies to fight with force and overcoming.

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